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On
Medicare Efficiency and Integrity
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Chairman Pallone, Representative Deal, and distinguished members of the Subcommittee, thank you for inviting me here today to discuss our efforts to promote efficiency and integrity in the Medicare program. The Centers for Medicare & Medicaid Services (CMS) has a track record of active engagement, ongoing through this day, with Congress, other state and Federal government partners, and the provider community with respect to these important issues.

At its inception, the fee-for-service (FFS) Medicare program was a mass purchaser of healthcare services, with CMS as a relatively passive payer. Given the size, broadened scope and impact of the program, both now and in the foreseeable future, CMS has begun to transform itself into a more active purchaser of high quality, efficient care for Medicare beneficiaries.

For the past six years, this Administration has made the efficient and effective management of Medicare and all of its programs an operational priority. Together with Congress, CMS has made great strides in modernizing and improving health benefits for people with Medicare. Central to its strategy for maintaining sound financial management, CMS has long used calculations of improper payments as a tool to preserve Medicare's fiscal integrity. Data collection and monitoring have enabled CMS to identify monies that have been inappropriately paid; to examine the causes of these improper payments, and ultimately, to strengthen internal controls to minimize them as much as possible.

The implementation of the Medicare Part D prescription drug benefit was a major step in modernizing Medicare and improving the quality of its services. Part D, enacted with passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and implemented in January 2006, has been a resounding success. To date, more than 90 percent of Medicare beneficiaries have prescription drug coverage through Part D or another creditable source, including nearly 10 million low-income individuals receiving coverage with low or zero premiums and nominal cost-sharing. Beneficiary satisfaction with Part D is consistently at 75 percent or higher, exceeding 90 percent among low-income beneficiaries receiving extra help.[1] Equally important, Part D premiums and estimated program costs have been declining steadily thanks in part to market forces— encouraging strong competition among plans and smart choices by beneficiaries—and in part because of lower-than-expected growth in prescription drug spending. Since last year, projected payments to Part D plans for the ten-year period of 2007-2016 dropped by $113 billion—$96 billion of which can be directly attributed to competition and lower plan bids. The average beneficiary premium for basic benefits is estimated at $22 per month for 2007—roughly 42 percent lower than the original projected premium of $37 per month.

Further, we are seeing increased enrollment in Medicare Advantage, the program through which beneficiaries can access integrated health and prescription drug benefits, often with lower premiums and cost-sharing than under traditional fee-for-service Medicare. Medicare Advantage is particularly important for lower-income beneficiaries, who may have difficulty paying Medicare's cost-sharing or private supplemental insurance premiums. Fifty-seven percent of Medicare Advantage enrollees report income between $10,000 and 30,000, compared to 46 percent of those enrolled in fee-for-service.[2] Further, racial and ethnic minorities represent 27 percent of total Medicare Advantage enrollment, compared with 20 percent in fee-for-service.[3] Enrollment in Medicare health plans has reached an all-time high of 8.3 million beneficiaries, up from 5.3 million in 2003.

[1] KRC Research survey for the Medicare Rx Education Network, conducted September 1-7, 2006.
[2] CMS analyzed the 2005 Medicare Current Beneficiary Survey (MCBS) to determine low-income and minority enrollment in Medicare health plans and in fee-for-service.
[3] CMS analysis of 2005 MCBS data.

Regardless of the care setting, CMS remains committed to improving the quality of patient care and to increasing the efficiency of Medicare expenditures. How Medicare pays for beneficiary services can significantly impact quality and medical costs not only for people with Medicare, but for our overall health care system. When payments are based primarily on admissions and procedures—rather than outcomes or efficiency—the system—our *current system*—risks paying for services that are ineffective, inefficient and/or inconsistent with best current information. CMS believes that a greater emphasis on recognizing and encouraging quality care would prevent complications and errors. That is why the Agency is modifying Medicare's FFS payment systems to improve quality, and at the same time, provide incentives for efficiency.

CMS recognizes the potential of the Medicare payment system to encourage and reward quality care in the hospital setting. This is particularly important, as it provides an opportunity to address quality concerns proactively. The MMA and Deficit Reduction Act of 2005 directed Medicare to pay more when hospitals and other health practitioners report on quality measures that empower both providers and patients, arm them with the raw material essential for informed decision-making, and ultimately, lead them to identify and pursue better care protocols. CMS is implementing several demonstration projects to encourage quality care and to lay the groundwork for value-based payments in the future. In addition, CMS is working toward greater transparency in physician and hospital pricing and quality data, providing consumers better information about treatment options available to them.

Fiscal Year 2008 Budget Proposals

The President's Fiscal Year 2008 budget proposes a plan for building on past successes to further modernize the Medicare program and secure its long-term future. Under current law, growth in net Medicare spending is approaching seven percent per year over the next five years and is anticipated to be higher than that over the next ten. Working closely with beneficiaries and providers, CMS believes it can improve the quality, efficiency and long-term viability of the Medicare program.

Federal Reserve Chairman Ben Bernanke, the Medicare Trustees, and the Medicare

Payment Advisory Commission (MedPAC) have underscored the importance of taking action *now* to address Medicare's long-term financial challenges. Chairman Bernanke warned the Senate Budget Committee at a January 18, 2007 hearing that "if early and meaningful action is not taken, the U.S. economy could be seriously weakened, with future generations bearing much of the cost." Voicing serious concern over Medicare's financial outlook in 2006, the Trustees insisted that "prompt, effective, and decisive action was necessary to address both the exhaustion of the Hospital Insurance Trust Fund and anticipated rapid growth in [Medicare] expenditures."[4]

The President's budget strives to induce providers toward greater efficiency with payment policies that increase the role of competition and create financial incentives for slowing cost growth through greater productivity and other improvements in care quality. Under current law, and based on the budgetary assumptions, the assets of the HI trust fund would start to decline in 2010. The Administration's proposals would improve the financial outlook of the HI Trust Fund throughout the ten-year window.
The net effect of the FY 2008 Medicare legislative and administrative proposals[5] is a reduction of nearly one percent in the rate of program growth over the five-year budget window. Specifically, they would save about $5.3 billion in FY 2008 and about $75.9 billion over five years.[6] Medicare's current average annual growth rate over the next five years is projected at 6.5 percent per year. Under the President's budget, the rate of growth would slow to 5.6 percent per year. Specifically, the budget would:

- **Foster Productivity and Efficiency:** Respond to inefficient health care delivery and rapid spending growth with provider payment adjustments that would account for expected productivity gains and induce providers to achieve efficiencies that restrain costs.
- **Rationalize Medicare Payment and Subsidies:** Tie payment to medical error reporting and expand value-based purchasing for hospitals; also

[4] 2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds at pp. 3-4.
[5] The Medicare budget assumes administrative savings of $1.0 billion in FY 2008 and $10.2 billion over five years. Savings will result from new efforts to strengthen program integrity in Medicare payment systems, correct for inappropriate provider payments, and adjust payments to encourage efficiency and productivity.

encourage appropriate payment for five common post-acute care conditions and address excessive Medicare payment and beneficiary coinsurance for power wheelchairs and oxygen equipment.

- **Improve Program Integrity:** Utilize a variety of data analysis tools to zero-in on the top ten vulnerabilities in the Medicare program, especially those with potentially high financial impact; and use such analyses to address and/or remedy the issues early in their lifecycle. An enhanced focus on data will enable CMS' program integrity efforts to be more proactive and less reactive, enabling a greater focus on actual fraud prevention rather than simply mitigation, after the fact.
- **Increase High-Income Beneficiary Responsibility for Health Care:** Eliminate annual indexing of income thresholds for reduced Part B premium subsidies, and extend the income-related Part B premium adjustment to Part D premiums.
- **Improve Long-Term Sustainability:** As a fall-back response in the absence of Congressional action, apply a -0.4 percent sequester to the Medicare payment amount for all providers in the first year that general revenue funding for the Medicare program exceeds 45 percent. The sequester reduction would grow by an additional 0.4 percent in each successive year that the general revenue funding remained above 45 percent.

Program Integrity in Fee-for-Service Medicare

Responsible and efficient stewardship of taxpayer dollars are critical goals of this Administration. Under the President's Management Agenda (PMA), a government-wide effort to improve financial management, federal agencies are mobilizing staff, resources and technology to identify improper payments in high-risk programs, establishing aggressive improvement targets, and implementing corrective actions to meet those targets expeditiously. Consistent with these efforts, CMS is committed to ensuring the highest measure of accountability within the Medicare program. Accordingly, the President's FY 2008 budget requests $183 million in discretionary HCFAC funding to build upon programs with a proven record for maintaining the integrity of the Medicare

Trust Funds. HHS plans to primarily use these funds for program integrity activities related to Part D and Medicare Advantage.

The majority of Medicare spending is in fee-for-service, with hospital and physician services currently representing the largest shares. The fee-for-service component also covers a range of other items and services, including home health care, medical equipment and ambulance and preventive services. CMS processes claims and makes payments for FFS Medicare benefits through contracts with private companies—Carriers, Fiscal Intermediaries (FIs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs).[7] These contractors review claims to ensure payment is made only for reasonable and necessary Medicare-covered medical services for eligible individuals. In addition, Quality Improvement Organizations (QIOs) are contractors that investigate beneficiary complaints about quality of care in hospitals and ensure payment is made for only medically necessary services.

The Improper Payments Information Act (IPIA) of 2002

Given the sheer size of Medicare program expenditures, even small payment errors can significantly impact the Federal Treasury and, by extension, taxpayers. As part of its longtime financial management strategy, CMS uses improper payment calculations to identify wrongdoing, strengthen internal controls, and ultimately, preserve Medicare's fiscal integrity.

Beginning in FY 2003, in concert with the Department of Health and Human Services Office of the Inspector General (OIG), CMS implemented a much more robust process—the Comprehensive Error Rate Testing (CERT) program—to assess and measure improper payments in the Medicare fee-for-service program. The CERT program not only produces a national paid claims error rate, but also very specific improper payment

[7] With the implementation of Medicare Contracting Reform (MCR) enacted by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Medicare contractor functions are being consolidated, and all contractors processing Medicare claims are called "Medicare Administrative Contractors" or "MACs." Although the durable medical equipment regional carriers (DMERCs) have been fully replaced by the DME MACs, while MCR implementation is underway, the original contractor terms – Carrier and FI – remain commonly used.

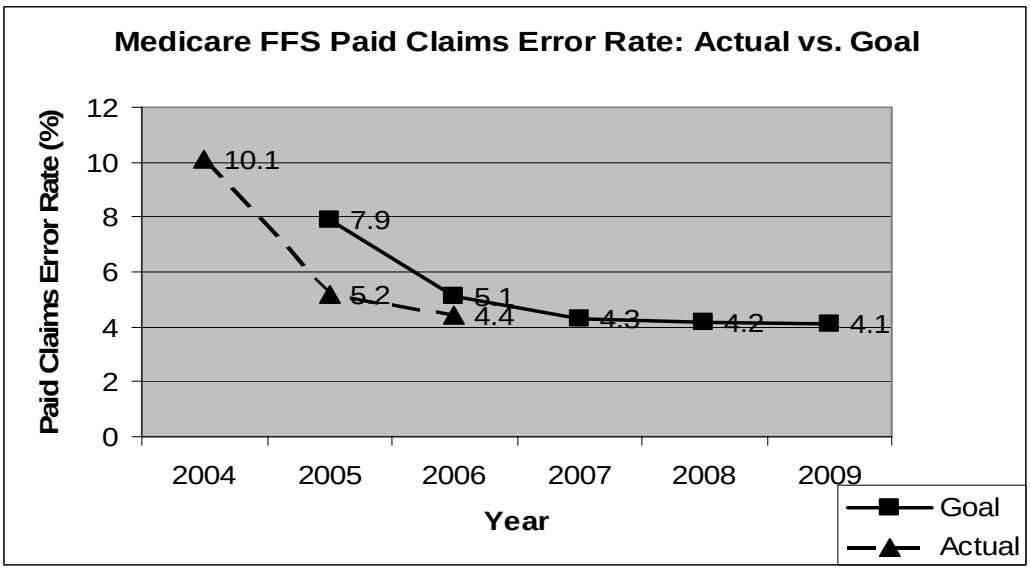
rates—contractor-specific, provider-type specific—and other management-related information, offering insight into payment errors by type and region.

Thus, in 2002 when the Improper Payments Information Act (IPIA) was enacted, CMS needed to make only minor changes to its ongoing processes for FFS Medicare to come into compliance with the Office of Management and Budget (OMB) guidance on the new law. In fact, CMS' efforts to crackdown on improper payments have gone *beyond* the scope of the IPIA requirements and Budget Office guidelines. This enhanced scrutiny reflects the Agency's increased commitment to use more detailed data and analysis to identify and eliminate improper payments.

Calculating improper payment rates is only one step in the process. Remediation is critical to CMS IPIA compliance activities. CMS, through its contractors, uses the error rates to identify where problems exist and to target improvement efforts. The cornerstone of these efforts is our annual Error Rate Reduction Plan (ERRP), which includes high-level strategies to clarify CMS policies and implement new initiatives to reduce FFS Medicare improper payments. In the past, ERRPs have included plans to conduct special pilot studies (i.e. electronic medical record submission pilot) and specific education-related initiatives. CMS also directs its contractors to develop local efforts to lower the FFS Medicare error rate by targeting provider education and claim review efforts to those services with the highest improper payments.

We believe our efforts in Medicare have been a success. In November 2006, HHS reported a Medicare FFS paid claims error rate of 4.4 percent, a significant decrease from the 5.2 percent reported in 2005, and significantly lower than the 10.1 percent rate reported in FY 2004. We have far exceeded our expectations, having reduced the error rate beyond the 2006 goal of 5.1 percent. With continued monitoring and error reducing efforts we aim to achieve our future targets of 4.3 percent in 2007, 4.2 percent in 2008, and 4.1 percent in 2009.

Figure 1:



Fraud, Waste and Abuse

CMS actions to safeguard Federal funds are not just limited to the error rate programs. Program and fiscal integrity oversight is an integral part of CMS' financial management strategy, and a high priority is placed on detecting and preventing fraud, waste and abuse. To that end, CMS has made significant changes to its program integrity activities in recent years.

The Program Safeguard Contractors (PSCs) are CMS' fraud, waste and abuse detection contractors. As of 2006, PSCs were established nationwide across all provider and supplier types in the Medicare FFS program. The PSCs perform data analysis to identify potential problem areas, investigate potential fraud, develop fraud cases for referral to law enforcement and coordinate Medicare fraud, waste and abuse efforts with CMS' internal and external partners (e.g., law enforcement, intermediaries, carriers, and MACs).

To further supplement the PSCs fraud identification efforts, CMS is making improvements to its own data analysis efforts. To achieve this, we are collecting vulnerability data from many of our partners, including Medicare contractors, and using a variety of data analysis tools to review claims data. Much of our work will focus on addressing vulnerabilities early on and those that have high estimated dollar impact to the

Medicare program. Our program integrity efforts will focus on the top ten vulnerabilities identified through our data analysis and on developing corrective actions to address these identified vulnerabilities.

Section 306 of the MMA gave CMS additional contracting authority to detect improper payments. The Secretary is directed to demonstrate the use of Recovery Audit Contractors (RACs) in identifying Medicare underpayments and overpayments, and collecting Medicare overpayments. CMS implemented RACs in three states – Florida, New York and California and in FY 2006, the RACs collected $68.6 million in overpayments and identified more than $300 million in improper payments.

The RAC demonstration is consistent with the President's Management Agenda (PMA) objective to prevent improper payments in federal programs. CMS designed the demonstration to accomplish two specific goals: to demonstrate whether RACs can identify past improper payments in the Medicare FFS program; and to determine whether the RACs can provide information to CMS that could help prevent future improper payments. It is clear that the RAC demonstration program accomplishes both of these goals. Given the success of this effort, Congress mandated the expansion of the RAC effort nationally in the Tax Relief and Health Care Act of 2006. CMS is now in the process of developing its expansion and implementation plans.

Provider Enrollment

CMS has seen a marked increase in fraud and abuse activities over the past few years that can be directly tied to provider enrollment issues. These activities are primarily focused in high vulnerability areas of the country such as Los Angeles, Miami and Houston where there are a large number of beneficiaries and providers/suppliers. CMS has undertaken numerous aggressive actions to tighten the provider enrollment process, provide more rigorous oversight and monitoring once a provider/supplier enrolls in the program, and strengthen the provider revocation process.

The fraudulent business practices of unscrupulous durable medical equipment, orthotics, prosthetics, and supplies (DMEPOS) suppliers continue to cost the Medicare program

billions of dollars. CMS is implementing new DMEPOS Accreditation Standards which will ensure DMEPOS suppliers meet CMS' supplier certification standards. All suppliers of DMEPOS must comply with the CMS quality standards in order to receive Medicare Part B payments and to retain a supplier billing number. The National Supplier Clearinghouse (NSC) will not be able to issue a supplier billing number to any non accredited supplier, thus any non-accredited supplier attempting to bill Medicare, will be automatically 'kicked-out' of the system.

To accommodate suppliers that wish to participate in the Medicare DMEPOS program, CMS will phase-in the accreditation process and require accreditation organizations to prioritize their surveys to accredit suppliers in the selected Metropolitan Statistical Areas and competitive bidding areas. All suppliers who require accreditation to bid in any CMS conducted DMEPOS competitive bidding need to be given priority by the approved accrediting bodies. Those suppliers in a non-competitive bidding area will be given a certain time frame in which to become accredited.

CMS is taking the following steps to better monitor a provider or supplier once it has entered the program:

- Implement claims specialty editing to ensure suppliers are only paid for items they are properly accredited to provide;
- Increase the number of random site visits to suppliers;
- Require greater claims scrutiny for high fraud risk suppliers;
- Deactivate providers with inactive provider numbers; and
- Provide additional resources for investigative staff to increase proactive initiatives by the NSC and the PSCs.

CMS is also implementing new strategies to remove fraudulent providers from the Medicare program. Our LA Satellite Office has recently identified situations in which some physicians are submitting claims for services that have not been furnished to a specific individual on the date of service. These instances include but are not limited to situations where the beneficiary is deceased, the directing physician or beneficiary was

not in the state or country when the services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred. We proposed through regulation that CMS have the authority to remove these abusive providers and suppliers from the Medicare program.

Conclusion

For eight fiscal years running, auditors have issued an unqualified opinion on CMS' financial statements. This accomplishment reflects the Agency's accountability for the public resources entrusted to us, and the dedication and commitment of our program and financial managers to achieve even stronger financial management.

The President's FY 2008 budget demonstrates a real commitment to improving America's health care system by further modernizing and improving Medicare. Steps taken now – or not taken – to adopt rational, responsible, and sustainable policies will directly impact our ability to preserve the promise of health care coverage for America's seniors, people with disabilities, and other vulnerable populations. We will continue to work to fully meet our fiduciary and operating responsibilities to our beneficiaries in years ahead.